

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0008490</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Fair Oaks</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>200 Healthcare Drive</u> <u>Greenville</u> <u>62246</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Bond</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>618-664-1230</u> Fax # <u>618-664-9750</u>		(Type or Print Name) <u>Jerry Graber</u>	
IDPA ID Number: <u>37-0792770003</u>		(Title) <u>CFO</u>	
Date of Initial License for Current Owners: <u>11/01/69</u>		Paid Preparer (Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) <u>NONE</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust		(Firm Name & Address) _____	
IRS Exemption Code <u>501-C-3</u>		(Telephone) <u>()</u> Fax # ()	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Jerry Graber</u> Telephone Number: <u>618-664-1230 ext.3100</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Fair Oaks# 0008490 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 10/01/03

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,528</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>108</u>	TOTALS	<u>108</u>	<u>39,528</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,905</u>	<u>15,115</u>	<u>1,378</u>	<u>34,398</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,905</u>	<u>15,115</u>	<u>1,378</u>	<u>34,398</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.02%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/69

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 108 and days of care provided 1,378Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Fair Oaks

0008490

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	232,155	34,184	15,972	282,311	(69,887)	212,424	104,895	317,319			1
2	Food Purchase		199,749		199,749		199,749		199,749			2
3	Housekeeping	97,266	19,741		117,007		117,007	30,506	147,513			3
4	Laundry	89,899	22,014		111,913		111,913	62,506	174,419			4
5	Heat and Other Utilities			161,931	161,931		161,931		161,931			5
6	Maintenance	105,174	50,764		155,938		155,938	52,590	208,528			6
7	Other (specify):* Support Services	47,794	4,329		52,123		52,123		52,123			7
8	TOTAL General Services	572,288	330,781	177,903	1,080,972	(69,887)	1,011,085	250,497	1,261,582			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,663,199	73,714		1,736,913		1,736,913		1,736,913			10
10a	Therapy			3,377	3,377		3,377		3,377			10a
11	Activities	40,483	6,796		47,279		47,279	(884)	46,395			11
12	Social Services	49,975	383	3,119	53,477		53,477		53,477			12
13	Nurse Aide Training	68,060	15,107		83,167	(48,982)	34,185	(34,073)	112			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,821,717	96,000	6,496	1,924,213	(48,982)	1,875,231	(34,957)	1,840,274			16
	C. General Administration											
17	Administrative	122,729	2,704		125,433	(6,332)	119,101		119,101			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			10,083	10,083	6,332	16,415	(6,332)	10,083			20
21	Clerical & General Office Expenses	45,564	39,961		85,525		85,525	5,868	91,393			21
22	Employee Benefits & Payroll Taxes			749,519	749,519	69,887	819,406	(8,898)	810,508			22
23	Inservice Training & Education					48,982	48,982		48,982			23
24	Travel and Seminar			4,610	4,610		4,610		4,610			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,000	54,000		54,000		54,000			26
27	Other (specify):* HR-Benefits-PTO	24,609	7,220		31,829		31,829		31,829			27
28	TOTAL General Administration	192,902	49,885	818,212	1,060,999	118,869	1,179,868	(9,362)	1,170,506			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,586,907	476,666	1,002,611	4,066,184		4,066,184	206,178	4,272,362			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fair Oaks

#0008490

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			104,129	104,129		104,129	22,151	126,280			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Minor Equipment			9,361	9,361		9,361		9,361			36
37	TOTAL Ownership			113,490	113,490		113,490	22,151	135,641			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,501	2,342	100,843		100,843		100,843			39
40	Barber and Beauty Shops			9,105	9,105		9,105	(9,051)	54			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,276	57,276		57,276		57,276			42
43	Other (specify):* Bad Debts			19,287	19,287		19,287		19,287			43
44	TOTAL Special Cost Centers		98,501	88,010	186,511		186,511	(9,051)	177,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,586,907	575,167	1,204,111	4,366,185		4,366,185	219,278	4,585,463			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,543)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(9,051)	40		12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(884)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,332)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(34,073)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (71,883)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	291,161	Page 6	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 291,161		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 219,278		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Fair Oaks

ID# 0008490

Report Period Beginning: 01/01/04

Ending: 12/31/04

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/04

[illegible]

Summary B

12/31/04

[illegible]

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Greenville Regional Hospital, Inc.	100					
(Name change from Edward A Utlaut Memorial Hospital, Inc.)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	6 MAINTENANCE	\$ 101,271		0.00%	\$ 153,861	\$ 52,590 1
2	V	4 LAUNDRY	31,459		0.00%	93,965	62,506 2
3	V	3 HOUSEKEEPING	58,744		0.00%	89,250	30,506 3
4	V	1 DIETARY	66,083		0.00%	170,978	104,895 4
5	V	21 TELEPHONE SYSTEM	52,817		0.00%	58,685	5,868 5
6	V	22 BENEFITS-LAB&XRAY SVCS	73,636		0.00%	80,539	6,903 6
7	V	22 BENEFITS-PHARMACY	32,042		0.00%	37,784	5,742 7
8	V	30 HOSPITAL SHARED AREA			0.00%		61,164 8
9	V	30 FAIR OAKS SHARED AREA			0.00%		(39,013) 9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 416,052			\$ 685,062	\$ * 291,161 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fair Oaks # 0008490 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Greenville Regional Hospital
 Street Address 200 Healthcare Drive
 City / State / Zip Code Greenville, Illinois 62246
 Phone Number (618-664-1230
 Fax Number (618-664-9750

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	Note:	Greenville Regional Hospital, Inc. operates Greenville Regional Hospital & Fair Oaks							2
3	Fair Oaks is charged for all known direct costs of operation.								3
4	Fair Oaks shares cost with the Hospital for certain services & therefore receives all allocations.								4
5									5
6	Of those expenses using applicable cost centers allocated to Fair Oaks are as follows:								6
7									7
8	DEPRECIATION(ONLY AT THOSE DEPARTMENTS THAT SHARE SERVICES)								8
9	ADMINISTRATION AND GENERAL								9
10	FINANCIAL SERVICES								10
11	DIETARY								11
12	OPERATING AND MAINTENANCE OF PLANT								12
13	HOUSEKEEPING								13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2	NONE											2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Fair Oaks	COUNTY	Bond
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 43,119

B. General Construction Type:
 Exterior
 Brink
 Frame
 Metal
 Number of Stories
 one

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		259,875	1957	\$	1
2					2
3	TOTALS	259,875		\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	74	1969	1969	\$ 992,165	\$		\$	\$	4
5	49	1974	1974	367,348					5
6		1981	1981	59,093					6
7									7
8									8
Improvement Type**									
9		1969	1969	6,835					9
10		1972	1972	927					10
11		1974	1974	6,528					11
12		1975	1975	3,058					12
13		1980	1980	543					13
14		1982	1982	17,661					14
15		1984	1984	66,863					15
16		1985	1985	7,721					16
17		1986	1986	10,764					17
18		1987	1987	30,588					18
19		1988	1988	30,786					19
20		1989	1989	15,099					20
21		1990	1990	25,662					21
22		1991	1991	26,807					22
23		1992	1992	23,815					23
24		1997	1997	9,666					24
25		1998	1998	23,932					25
26		1999	1999	76,550					26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	North Wing Renovation	2000	\$ 14,734	\$		\$	\$	\$		37
38	South Wing Automatic Door Installation	2000	4,929							38
39	Activities Room Renovation	2000	8,653							39
40	Parking Lot Expansion	2000	135,861							40
41										41
42	East Wing HVAC Repair	2001	18,150							42
43										43
44	Canopy Project	2002	179,280							44
45	East Wing HVAC Repair	2002	29,040							45
46										46
47	North Wing Nurse's Station Renovated	2003	6,794							47
48										48
49	HVAC Units Replaced	2004	18,230							49
50	Dinning Room Renovated	2004	42,249							50
51	Scheduling Office Renovated	2004	3,400							51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,263,731	\$ 71,180		\$ 71,180	\$	\$ 1,352,133		70

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

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Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 404,584	\$ 26,205	\$ 26,205	\$		\$ 438,136	71
72	Current Year Purchases	138,505	4,644	4,644			4,644	72
73	Fully Depreciated Assets							73
74	Transfers	(22,863)					19,137	74
75	TOTALS	\$ 520,226	\$ 30,849	\$ 30,849	\$		\$ 461,917	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activities	Ford Bus-2004	2004	\$ 42,000	\$ 2,100	\$ 2,100	\$		\$ 2,100	76
77										77
78										78
79										79
80	TOTALS			\$ 42,000	\$ 2,100	\$ 2,100	\$		\$ 2,100	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,825,957	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 104,129	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,129	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,816,150	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

A. Building and Fixed Equipment (See instructions.)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES ☐ NO

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

☐ YES ☐ NO

C. Vehicle Rental (See instructions.)

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies			9,641	9,641
3	Classroom Wages (a)		2,936		2,936
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)			21,608	21,608
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 2,936	\$ 31,249	\$ 34,185
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,936			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ 34,073

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	99
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	3
TOTAL TRAINED	108

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts			2,342	98,501		100,843	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$		\$ 2,342	\$ 98,501		\$ 100,843	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	241,647	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 939,000)	3,716,859	3,716,859	3
4	Supply Inventory (priced at)	215,530	215,530	4
5	Short-Term Investments	510,962	510,962	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	365,126	365,126	7
8	Accounts Receivable (owners or related parties)	10,248		8
9	Other(specify): Due from IDPA	240,000	240,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,058,725	\$ 5,290,124	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	32,483,389	34,601,827	16
17	Accumulated Depreciation (book methods)	(11,601,930)	(12,439,825)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	860,878	6,930,658	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	461,899	461,899	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 22,204,236	\$ 29,554,559	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 27,262,961	\$ 34,844,683	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,570,449	\$ 1,570,449	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	432,931	432,931	29
30	Accrued Salaries Payable	618,437	618,437	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	90,963	90,963	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	38,026		35
	Other Current Liabilities(specify):			
36	Accrued Expenses	339,536	372,927	36
37	Due to Medicare	173,360	173,360	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,263,702	\$ 3,259,067	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,267,906	11,267,906	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,267,906	\$ 11,267,906	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,531,608	\$ 14,526,973	46
47	TOTAL EQUITY (page 18, line 24)	\$ 12,731,353	\$ 20,317,710	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 27,262,961	\$ 34,844,683	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,544,004	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,544,004	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,010,601)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Hospital-Net Income	1,309,044	15
16	Other (describe) Emerald Pointe-Net Loss	(88,757)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 209,686	17
	B. Transfers (Itemize):		
18			18
19	Due to Affiliated Organizations	977,663	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 977,663	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,731,353	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,922,833	1
2	Discounts and Allowances for all Levels	(610,964)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,311,869	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	33,780	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,051	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	884	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,715	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,355,584	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,080,972	31
32	Health Care	1,924,213	32
33	General Administration	1,060,999	33
	B. Capital Expense		
34	Ownership	113,490	34
	C. Ancillary Expense		
35	Special Cost Centers	129,235	35
36	Provider Participation Fee	57,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,366,185	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,010,601)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,010,601)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Fair Oaks

0008490

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	5,058	6,244	\$ 121,402	\$ 19.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,463	11,683	241,425	20.66	3
4	Licensed Practical Nurses	17,128	21,146	327,068	15.47	4
5	Nurse Aides & Orderlies	73,427	90,651	959,500	10.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,174	3,919	40,483	10.33	9
10	Activity Assistants					10
11	Social Service Workers	3,131	3,866	49,975	12.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,517	24,095	232,155	9.63	15
16	Dishwashers					16
17	Maintenance Workers	5,666	6,995	105,174	15.04	17
18	Housekeepers	8,780	10,840	97,266	8.97	18
19	Laundry	8,007	9,885	89,899	9.09	19
20	Administrator	3,379	4,171	108,123	25.92	20
21	Assistant Administrator					21
22	Other Administrative	714	882	14,606	16.56	22
23	Office Manager					23
24	Clerical	2,578	3,183	45,564	14.31	24
25	Vocational Instruction	2,546	3,143	68,060	21.65	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	834	1,030	13,804	13.40	31
32	Other Health C: Support Svc	1,609	1,986	47,794	24.07	32
33	Other(specify) HR-BENEFITS-P	1,092	1,348	24,609	18.26	33
34	TOTAL (lines 1 - 33)	166,103	205,067	\$ 2,586,907 *	\$ 12.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 15,972	1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,342	39	39
40	Physical Therapy Consultant		3,377	10	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,119	12	45
46	Other(specify)		9,105	40	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,915		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Fair Oaks

STATE OF ILLINOIS

0008490

Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? YES If YES, what is the capacity? 108
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,276
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 69,887 Has any meal income been offset against related costs? YES Indicate the amount. \$ 21,543
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BKD,LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.